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January 7, 2009

I. INTRODUCTION

In response to the call of President-Elect Barack Obama and Secretary of Health and Human Services nominee Tom Daschle to hold Health Care Community Discussions, and in consultation with Senator Charles Schumer, who will have a significant role in health care reform, Nassau County Comptroller Howard S. Weitzman invited some of the County's brightest minds in the area of health care to join him for one of these historic meetings. On December 22, 2008, 22 of Nassau County's health care providers, health care consumers, health care attorneys, business and union leaders came together at Comptroller Weitzman's home and discussed the current state of the nation's health care crisis, debated viable solutions and shared light refreshments in the spirit of the holidays. This report summarizes the discussions that night and presents some important issues and solutions that need to be considered by the health care transition team as it moves forward with its agenda for health care reform.

II. DISCUSSION

A. The Existing Health Care System is Broken

Everyone agreed that the existing health care system in the United States is fragile and broken. In 2007, health care accounted for approximately 16% of the gross national product, and is expected to rise to 20% by 2016. This level of growth in the cost of the system is not sustainable. While we have the most expensive health care system in the world, we are not delivering results commensurate to the amount of spending. The system is failing Americans everywhere because it does not serve businesses that are struggling to fund the cost of insurance for their employees, the sick who are going bankrupt to pay for services that are not covered by insurance, and the uninsured who are going without any consistent health care at all. Change must

ensure that all Americans receive the quality care that they deserve and that we as a nation are funding.

B. Universal Health Insurance Must be at the Core of the Reform Effort

The group agreed that a universal health insurance program available for all Americans should be at the center of the nation's health care reform. While the opinions differed about how such a program would be implemented, there was a general consensus that health care is a basic right and providing health insurance is essential to ensuring Americans' health and treatment when they become sick. Starting with the basic premise that everyone should have access to health insurance will resolve many of the difficulties of the current system. There were however, varying ideas about how such a plan should be implemented. Some considerations that need to be addressed in the plan follow.

1. Incremental Change vs. Fundamental Reform. Most of the group thought the system should be overhauled in a single, bold aggressive movement, although a minority argued for a long-term strategic plan that would be more gradual. If the nation were not currently facing an economic crisis, the group would have voted for radical change by a wide margin.

   Those in favor of sweeping transformation of the system felt that incremental change does not work. The nation successfully and dramatically increased access to health care by implementing Medicare, which was a sweeping change. The new administration and the economic crisis provide a tremendous opportunity to reform health care. Now is the time to forge a consensus to think differently about health care and the health insurance that funds it. Further, some believe that without sweeping change, the economy will not be able to handle the financial impact of reform. The entire system needs to be restructured so that it can sustain itself. Thus, this group was of the opinion that the basic system should be reformed immediately, and then the imperfections in the details could be addressed in subsequent phases.

   Those in favor of a more gradual approach were concerned that the nation's economy cannot handle a sweeping change in health care finance. Further, they felt that Americans would be more receptive to gradual change.

2. Mandatory Health Insurance. The group generally agreed that requiring all Americans to have some level of health insurance that will provide basic primary and preventative care will rationalize the insurance costs across more people, and will encourage more Americans to get the health care they need before their medical issues go undiagnosed and become life threatening.

3. Expansion of Medicare. Medicare is the most successful health care program in the nation. If Medicare were universally offered to Americans, it could be the basis for providing access to health care for all. Taxpayer subsidized Medicare could be offered to employers who want to offer their employees insurance, but cannot afford private programs, people over 55 years of age who do not qualify for Medicare under the current

system and cannot afford private health insurance, and anyone else who is uninsured, on a sliding scale that would determine their level of responsibility based on need.

Some thoughts on how this might work:

- Medicare would be universally offered to everyone; however, individuals and employers could still keep private health insurance if they chose to.

- The number and types of plans that could be offered would be limited so that everyone would understand what was covered and what their own obligations were under the plans. There was agreement that administrative savings would come from presenting fewer choices, but some members disagreed with this policy prescription and thought government should not direct the scope of coverage. Plans could be structured with differing levels of coverage that would be tied to the amount that people are paying into the plan. There was some concern about whether allowing people to pay for better coverage would be truly offering health care for all, while others argued that people who can pay for better care should be offered "excess coverage" that would not be part of the basic Medicare plans.

- Employers would continue to provide health insurance, though their role, and therefore their costs, would change. The employer program could work similar to Medicare Part B. The government program would pick up the cost for a majority of the health care costs, with caps on the amount that could be charged, and the employer would cover the remainder, either directly or through excess insurance coverage.

- Private insurers would continue to have a role in the health insurance business. They would be able to compete on price within the structure of the limited plans offered under the universal health insurance program, and would be the primary providers of excess insurance.

- Insurance companies could be equalized through reimbursements between insurers. Private insurers who cover higher risk people would receive a payment from companies who insure lower risk individuals so all companies are on equal financial footing, and there is no incentive not to cover an individual. Subsidies to private insurers must end.

- A financing study would be necessary to determine what people would be charged for varying programs. The requirements for publicly funded health insurance are now tied to the percentage of the federal poverty level as determined by the states, but in reality, there are many individuals who do not meet those levels and still cannot afford health insurance. A sliding scale for payments would have to take into account differences in regional cost of living.

- Overall, the group agreed that expanding Medicare would be the easiest and fastest solution because the government already has an effective national program in place.

4. Long Term Care needs to be included in a comprehensive health care program. The current system does not work for long term care either. It treats long term care insurance separate and apart from health insurance. Long term care planning is aimed at becoming Medicaid eligible. Insurance companies and estate planners are legally marketing products that allow people to qualify for aid and at the same time keep or transfer their assets.

   Long term care should be addressed in a more direct and rational way. The system could be structured so that people have the option of either using their own assets to pay for long term care until they run out and then receive taxpayer funded care, or retain some or all of their assets but pay into a long term care fund similar to a long term care insurance policy.

5. Prescription Drugs and the Future of Medicare Part D. While it is clear that any universal coverage program needs to include prescription drugs, the group seemed divided on whether the Medicare Part D program should be incorporated in its current form. Those in favor of the program said that as the first major modification in Medicare in about 20 years, it was a huge step forward in the overall Medicare program. Those in favor of a restructuring believe there are a number of problems with the program.

   - The paperwork is not consumer friendly, creating an access issue. No one understands the competing plans. A group member said that he, a knowledgeable member of the health care community, was having difficulty sorting through the forms and therefore it is completely unfair to expect the average senior citizen to understand the documents.

   - The "donut hole" penalizes the sick, and is especially harmful to lower income people since they cannot afford to pay $2500 for prescriptions.

   - The prohibition on government negotiations with drug companies drives up the costs of prescriptions.

   - Programs to encourage generic drugs utilization should be part of any prescription plan. This would be an enormous cost saver for the program.

   - A reimbursement system with negotiated rates similar to the Veterans' Administration program might be a better plan, although some members were concerned about the VA program and said it was not a perfect model.

6. Role of the States. The group seemed to disagree about whether the states should continue to have a role in administering the universal health insurance program. Some felt that besides providing some financial support for the programs, the states only added another layer of bureaucracy. Others saw the intrinsic value of giving the states some flexibility in creating programs that work for their residents. For example, one participant described New York State's adult daycare program as an example of a hugely

successful program that ultimately saves money by keeping people in their homes and out of institutions. Participants also discussed that states will play a continuing role in regulating medical providers and therefore should have a role in setting policy and managing quality of care issues within their jurisdiction.

7. Health Care Policy and National Economic Policy. As the nation has witnessed the unfolding financial crisis, it has become clear that the rising costs of health care are a significant driver of the economic woes of the country. The cost attributable to employee health care is making U.S. businesses unable to compete with their foreign counterparts. We need to have a health plan that will relieve some of this burden from the American businesses that are expected to increase employment as the economy recovers.

8. Rational Regulatory Changes. The group was concerned that a new health care program needs to be insulated from politically motivated regulatory changes, which tend to harm patients in the end. There must be an evidence based decision-making structure built into the system that is tied to improving health care. Participants also said that constant changes in regulations, no matter how sensible each might be, are harmful to providers and make compliance very difficult.

C. Paying for Health Care

Any national reform initiative is going to have an incremental cost at the beginning. The new system will inevitably face pent up demand from people who were previously unable to get health care and therefore will need to cover the associated treatment costs. Thus, it is essential that the government find a way to cover those costs. Many of the participants believe that despite the increased costs during the early stages, a program that extends access to health care for all will ultimately reduce the costs of a system that allows people to go uninsured because less will go undiagnosed and untreated at the early stages of their medical conditions. Preventative screenings and early detection of chronic conditions should reduce the instances of unforeseen emergencies that require long term and costly care.

One member of the group shared the story of a friend who did not have health insurance and therefore was going untreated for hypertension, a chronic but treatable condition. As a result, she had a stroke, and was permanently disabled, needing constant care in an institution, which was funded by Medicaid. Extending the tragedy, and demonstrating how expensive the current system can be, her four children were put into the foster care system – another publicly funded program. This is an example of how incremental upfront costs of screening, treatment and availability of prescription medications would have been a fraction of the long-term costs of institutionalization and foster care.

D. The Role of Employers

In a reformed health care program employers should continue to fund health insurance for their employees. They could either continue with private health insurance or pay into the federal program, which participants anticipated would be less expensive than the current costs of private health insurance. The goal would be to maintain the employee's level of insurance at a lower cost to

the employer. If an employer does not offer insurance, it would be taxed at the level it costs the government to insure its employees.

E. Access to Quality Health Care for All

The group agreed that disparities in access to quality health care must be addressed in the health care reform initiative. While offering health insurance to all Americans is a good start, health insurance does not always equate to access to health care. Throughout the nation there are communities that have an inadequate number of doctors, which results in people not receiving the essential medical services that they need. Further, studies of Medicare have shown different outcomes for white and African American patients with the same disease. There are continuing problems with accurately diagnosing and treating individuals, particularly members of minority communities.

To improve access to quality health care for all, the following issues must be addressed:

1. Access to care. Areas where there are disparities in the number of health care providers needs to be proactively addressed. The program could include incentives for providers to maintain offices in underserved areas, and fee schedules could include disparity indicators.

2. Transportation. In areas that are lacking in providers, people in need of health care can find that it is too difficult to obtain transportation to health care providers. Expensive and time consuming transportation becomes a roadblock to health care. Either more providers have to be available in low-income communities or a way to fund and provide transportation to health care centers needs to be found.

3. Education and Care Management. Patients need to be educated about how to take care of their health and their treatment. Too many people in lower income areas are unaware of the services that they need or where they can obtain follow up medical care. In all communities, disease management needs to be improved. Care management is essential in underserved areas. It increases the chances that people who need assistance will receive it. Some participants thought that the country would be healthier if everyone had a medical provider with responsibility for their care, so that it would always be clear where to go for medical care.

4. Cultural Sensitivity. Providers need to be sensitive to the needs of the patients and understand that people from different cultures often have different medical concerns.

5. Patient Protection. The new national program must put patients first. It should reimburse doctors at a rate that will allow them to provide quality health care to their patients without being concerned about paying their own bills. Reimbursements to providers should be standardized and simplified.

F. Modernizing Health Care

The group agreed that any new health care system needs to be modernized and should take advantage of existing technology to improve patient care. Everyone seemed to agree that universal electronic health care records are one of the most important investments that can be made in the program to control costs. It would also improve patient care because it would allow people to carry medical ID cards that make access to medical information such as past history, prescription drugs, health insurance information simple and efficient. Electronic records would also facilitate creation of databases that would prove which treatment protocols were more effective and would help disseminate that information to practitioners.

G. Eliminating Factors that Drive up the Cost of Care

Under the current health care system, there are a number of factors that increase costs. Any new program that is put in place must address these weaknesses in the current system. The group was not, however, agreed on whether these issues should be dealt with in the initial roll out of the heath care plan or in a second phase of the program. Those who felt they should be dealt with immediately were of the view that without reform of the existing wasteful practices, the new program will be too expensive to sustain itself. The opponents of dealing with these issues immediately felt that they could hijack the important work of getting a universal program in place. Here are some of the general concerns that were discussed:

- Fraud. The issue of insurance fraud needs to be tackled head on. It is a key driver in health care costs and results in increased insurance costs.

- Improve Care Management. The current system encourages doctors to over treat and over test patients because it pays professionals based on the number of treatments they give. It also permits patients to continually seek treatment, even when it is medically unnecessary. It is essential that the new health care program include case management, a disease management program, and wellness/preventive programs. This will not only curtail over usage, but it will also improve the quality of care that a recipient is receiving.

- Cost of Malpractice Insurance. The steadily increasing cost of malpractice insurance is driving doctors out of some practice areas because the expense is so large. New York is seeing a health care crisis in the area of obstetrics as a result of the cost of malpractice insurance. In Brooklyn, New York, the hospitals are getting out of the business of delivering babies because the malpractice insurance costs are so huge. About half of insurance costs in some local hospitals are due to the malpractice insurance for the obstetrics department.

  The current system also causes doctors to engage in over testing and prescribing because they are concerned about their liability if they fail to act. Participants discussed whether a no fault model, where catastrophically injured people would have the care they need, could help improve this concern. Participants agreed that the states

need to do a better job of reviewing and revoking the licenses of doctors who are committing malpractice.

III. CONCLUSION

The Health Care Community Discussion was a great way to begin the discussion about health care in America. The diverse group of individuals that attended this Discussion brought innovative ideas and a fresh perspective to an old problem. Now is the time to embrace these ideas and bring them forward to create a new system that works for the entire nation.

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